



7540 Little River Turnpike Ste H
Annandale, VA 22003
Phone: 703-256-2600
Fax: 703-256-6566

NEWBORN/PEDIATRIC INTAKE

Date: _____

Name (First, MI, Last):	Preferred Name:	Date of Birth:	Age:	Sex:
Home Address/City/Zip:				
Primary Contact for Minor:	Primary Contact Phone:	Primary Contact Email:	Relationship to Patient:	
Emergency Contact for Minor:	Emergency Contact Phone:		Relationship to Patient:	
Personal Physician:	Office Address/Phone:			
Pharmacy Name/City/Phone:				
How did you find out about our practice? (Referred, online, etc.)				

Pediatric Medical History

What is the main reason(s) for seeing the patient? _____



7540 Little River Turnpike Ste H
Annandale, VA 22003
Phone: 703-256-2600
Fax: 703-256-6566

Please check the box next to any medical condition the patient currently has or has had in the past:

Seasonal Allergies	Recurrent Sinus Infections	
Headaches (migraines, etc.)	Dizziness	
Seizures	Nausea	
Psychiatric Illness (depression, anxiety, etc.)	Asthma/Lung Problems	
Chronic Bronchitis	Chest Pain	
Irregular Heartbeat	Bleeding/Clotting Disorder	
Indigestion	Heartburn/Stomach Ulcers	
Dental Problems (cavities, etc.)	Constipation/Diarrhea	
Kidney Disease	Hepatitis/Liver Disease	
Skin Problems (Acne, etc.)	Back Pain/Sciatica	
Herniated Disc	TMJ	
Chronic Muscle, tendon, or Joint Pain	Chronic Pain Syndrome	
Diabetes	Thyroid Problems	
Eye Problems (Glaucoma, etc.)	Psoriasis/Eczema	
Hives	Vertigo	
Menstrual Disorders	MS	
Neurologic Problems	Concussion/Brain Injury	
Sleep Disorders (Insomnia, Apnea, etc.)	ADHD/ADD	

Please list any additional health problems not listed above: _____

Allergies (foods/medications/environmental): _____

Current Medications/Supplements: _____

Past Surgeries/Traumas: _____



7540 Little River Turnpike Ste H
Annandale, VA 22003
Phone: 703-256-2600
Fax: 703-256-6566

Immunization History (check off all that apply):

DTap/Td	
MMR	
Pneumonia	
Flu	
Gardasil	
Hepatitis A/B	
Meningococcal	
Other	

Dental History (check off all that apply):

Amalgams/Silver Fillings	
Crowns	
Root Canals	
Metal Retainers/Braces	
Implants	
Cavities	
Mouth Guard	

Females Only (if applicable):

At what age did the patient start menstruating? _____

First day of last menstrual cycle: _____ Average days of cycle: _____

Cycles are generally (check all that apply): ____ Regular ____ Irregular ____ Nonexistent

HIPAA NOTICE OF PRIVACY PRACTICES

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information.

Your signature below is only acknowledgement that you have received this Notice of our Privacy Practice

AUTHORIZATIONS:

- A. I hereby authorize release of any medical information necessary to process a claim and request payment of insurance benefits either to myself or to the party who accepts assignment.
- B. I authorize payment of any medical benefit from third parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.



7540 Little River Turnpike Ste H
Annandale, VA 22003
Phone: 703-256-2600
Fax: 703-256-6566

- C. I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for products or professional services rendered will be immediately due and payable.

Patient Name: _____

Parent/Guardian Signature: _____ Date: _____

Office Policies

All appointments require 24 hours' notice in advance of cancellations prior to appointment time. Failure to notify office staff in cases of cancellation or rescheduling prior to the 24-hour time frame will result in a **\$100 no-show fee. ALL APPOINTMENTS MUST BE CONFIRMED PRIOR TO THE APPOINTMENT TIME IN ORDER TO AVOID APPOINTMENT CANCELLATIONS AND FEES.**

Visits to our office MUST be paid when services are rendered. We accept cash, checks and most major credit cards.

Some of the services provided at Health Builders PC are covered under standard insurance policies. However, with the diverse selection of insurance plans, levels of coverage and frequent changes, it is not always possible for our office to keep up with all plan requirements. While we do our best to inform you of the requirements, you are ultimately responsible for understanding your insurance policy. Dr. Kim and Dr. Fuller are out-of-network providers, so out-of-network benefits apply once the applicable deductible has been met. For visits that require written authorization from your primary care physician (PCP) to see a specialist, it is your responsibility to obtain a valid authorization from your PCP for each visit. Authorization cannot be issued retroactively. Without authorization, you may not be seen. If you choose to be seen without proper insurance authorization, you agree to waive your health plan benefits and agree to be personally and fully responsible for payment for any services rendered.

Health Builders PC employs diagnostic and treatment methods that are traditional and nontraditional. Because we look for imbalances in the body and for trends that may result in illness if not addressed (a preventive approach), we may order tests not considered by insurance to be 'necessary' or standard of care. **We employ diagnostic tools and treatment modalities that include but are not limited to chiropractic, acupuncture, physiotherapy, electrodermal testing (Asyra), muscle testing (NRT), Neuro-emotional Technique (NET), Neural therapy, Emotional Freedom Technique (EFT), intravenous vitamin therapy, nutritional supplements, homeopathy, and herbal therapies. By signing this, consent is given for the above modalities as it pertains to my office visits.**



7540 Little River Turnpike Ste H
Annandale, VA 22003
Phone: 703-256-2600
Fax: 703-256-6566

I have completed the prior information as accurately as possible and to the best of my knowledge. I have read the Privacy Policy as mandated by HIPAA. I authorize treatment by Drs. Fuller and Kim with the understanding that there are no guarantees or claims that I will be helped by undergoing treatment here. I understand the collaborative nature of entering into a health agreement with my providers whose goal is to assist me in optimizing my health.

Parent/Responsible Party Signature _____ Date _____

Credit Card Authorization Form

A valid credit or debit card MUST be kept on file to save all New Patient appointments. Payment will not be made at the time of scheduling, but it is required to hold the appointment for the patient.

The card on file may NOT be an HSA or FSA card.

Patient's Name _____ Name on Card _____

Credit Card # _____ Exp _____ CVC _____

Billing Zip Code Associated with Card _____

I, _____, authorize Health Builders, PC to keep my credit card on file and bill by credit card for cancellation fees, payment of services, laboratory fees and supplements as needed.

Explanation of Payment and Cancellation Policy

Payment is due at the time of service. We are an out-of-network provider, meaning we do not accept any insurance for payment for services.

It is necessary to cancel your scheduled appointment at least 24 hours in advance to avoid cancellation/fees. **The card will not be charged unless the patient cancels after 24 hours prior to the appointment time, "no-shows", or does not confirm via email, text message, or phone call prior to the appointment. Our scheduling system sends automatic reminders to confirm appointments beforehand via email and text message.**

You may request to void this authorization after the initial visit to remove the payment information from your chart. Otherwise, the card on file will only be used for cancellation fees or if otherwise authorized by the cardholder.